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Is There A Proctor In the House? The Liability of Surgical Proctors for the Negligence of Observed Physicians

I. Introduction

A "proctor" is often described as a "supervisor" or "monitor" and specifically, "one appointed to supervise students (as at an examination)." *See* Merriam-Webster's Collegiate Dictionary, Eleventh Edition. Although one can easily understand the role of a proctor in a classroom setting, the role of a proctor in an operating room setting can be more complicated, especially when it comes to the ultimate responsibility for the care of a patient. Proctoring by experienced surgeons is a common and increasingly frequent method to credential surgeons for hospital privileges, or those who are new to laparoscopic or robotic procedures.

A surgical proctor generally consists of a surgeon observer who is responsible for the assessment of the skills and knowledge of the surgeon learner during the initial phase of the learning curve. *See* Kevin C. Zorn, *The Journal of Urology*, 182 J UROL 1126-32 (2009). The proctor reports his or her findings to the applicable governing body in charge of evaluating the subject surgeon and provides recommendations based on his or her findings. *Id*. Proctoring can also involve responding to questions about the surgical equipment being used without participating in the medical decision making involved in the procedure. Advanced technology has gone so far, through the use of teleproctoring, as to creating situations where the surgeon is not physically on site with the patient. *Id*. Accordingly, a proctor is generally not involved in any medical decision making or in the actual performance of the procedure being observed.

II. A Real World Case of a Proctor in a Prostate Removal

Recently, Lee Weatherly and Karen Salmon were involved in a case involving such a proctor. Lee's client, and Karen's insured, was named in a multi-party lawsuit over complications following a robotic prostatectomy. The physician was serving as the surgical proctor for the two primary surgeons who were completing their eighth robotically assisted prostatectomy. Undetected by the primary surgeons, a portion of the patient's prostate gland remained inside the patient's body after the surgery. The primary surgeon subsequently chose to irradiate the patient, which resulted in radiation-induced urinary strictures and resultant bladder diversion.

III. Insurance Coverage for Proctor Services

In a review of the limited law on this issue during the course of this litigation, we found that a surgical proctor, who acts only as an observer, should not have any medical malpractice liability should a procedure be performed below the standard of care. The reasoning behind the legal system's reluctance to hold proctors liable for the treatment of those they observe is due to the lack of a physician-patient relationship between the proctor and patient. However, those defending surgical proctors should be aware of the distinctions that courts have used to find that malpractice liability did not exist so they can frame their cases to mirror these factual scenarios. Further, medical malpractice insurers and hospital risk managers should recognize this emerging practice and ensure that they have the proper insurance coverage and/or legal protections in place for proctors observing other physicians.

Many insurance policies, such as the one involved in this case, only provide insurance coverage for "medical professional services provided or withheld in jurisdictions in which the doctor is properly licensed as a medical professional." Although insurance coverage could be withheld in many cases where out-of-state medical professionals are acting as proctors, that is often not the best decision for the insured or the insurer.

III. The Role of Hospitals in Using Proctors

Across the United States, hospitals are using proctors to assist in the credentialing of physicians and surgeons. Similarly, many hospitals are requiring surgeons to be proctored for a number of procedures when they first begin to use new equipment, such as robotic laparoscopic devices. The assistance of a knowledgeable proctor in these situations can be very helpful to the hospital in making the determination if the observed surgeon is qualified to offer these new services to the general public.

Although the proctor is often the most experienced surgeon involved in a surgical procedure, they must be careful not to interject themselves into procedure outside of an observational role. A proctor should remain outside the sterile field, not scrub in and not participate in the medical decision making during the procedure. A pre-surgical discussion or review of the patient's chart is generally acceptable behavior for a proctor. Nevertheless, a surgical proctor must ensure that their primary role is to act only as an observer. Should a proctor stay within those guidelines, they should not have any medical malpractice liability should a procedure be performed below the standard of care. However, should a proctor expand their role to assist or advise in the performance of the procedure, the proctoring surgeon can expect to be brought into cases even where their role in the patient's care was minimal if their participation rose to the level of supervisor or preceptor. Further, if a proctor is not credentialed at the hospital and/or licensed in the state where he is proctoring, he should seek a waiver from the patient asserting there is not a physician-patient relationship between the patient and the proctor.

The existence of a physician-patient relationship is a prerequisite to recovery in a medical malpractice case. *See Roberts v. Hunter*, 426 S.E.2d 797 (SC 1993). "The establishment of a doctor/patient relationship is a prerequisite to a claim of medical malpractice [and] [t]he relation

is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as a patient." *Id*. The South Carolina Supreme Court's reasoning in *Roberts* is mirrored in cases nationwide which hold that no doctor/patient relationship exists when a doctor neither examined nor participated in the treatment of a patient. *See, e.g., Irvin v. Smith*, 31 P.3d 934 (Kan. 2001); *Doherty v. Hellman*, 547 N.E.2d 931 (Mass. 1989); *Rand v. Miller*, 408 S.E.2d 655 (WVa. 1991). Ordinarily proctoring duties do not include treating or examining the patient and most times the patient never meets the proctor of his or her surgery. However, there can be a fine line between proctoring a procedure and participating in a procedure, possibly unknowingly creating a physician-patient relationship. There are also states where the doctor/patient relationship may artificially extend to third parties who may benefit from the medical professional practicing within the standard of care. *See Pate v. Threlkel*, 661 So. 2d 278, 281 (Fla. 1995).

A proctor's immunity from suit based on the lack of a physician-patient relationship may be tenuous if the proctor undertakes a voluntary duty to participate in the procedure. Such an act could create a physician-patient relationship and transform a proctor into the role of a "preceptor." Preceptoring is generally a form of training whereby an experienced surgeon scrubs in or supervises the procedure with the intention of guiding the surgeon learner and assisting in the acquisition of the new skills by providing feedback and aiming to transfer skills in a hands-on approach. *See* Kevin C. Zorn, *The Journal of Urology*, 182 J UROL 1126-32 (2009). Unlike a proctor, where the observed surgeon has the responsibly for the care of the patient, a preceptor is the primary person responsible for the well-being of the patient and can take over the surgical procedure if the situation requires. *Id*. Therefore, unlike proctors, preceptors have a physician-patient relationship with the patient and can be legally liable for failing to intervene in a patient's care. *See, e.g., McCullough v. Hutzel Hospital*, 276 N.W.2d 569 (Mich. 1979). While surgeons are often labeled as "proctors" by the entity requesting that they observe another surgeon for credentialing purposes, they must be careful not to interject themselves into a procedure to a degree that they could be described as "preceptors," creating liability for themselves in relation to the observed procedure.

Only two states have tackled the specific issue of the liability of proctors in the operating room: California and Ohio. In *Clarke v. Hoek*, 219 Cal. Rptr. 845 (Cal. Ct. App. 1985), the California Court of Appeals expressly held that a surgeon acting as a medical proctor does not owe a duty of care to a patient because there is no physician/patient relationship between the two. *Id.* at 214, 849. In *Clarke*, the proctor surgeon, Dr. Hoek, an orthopaedic surgeon, was an active medical staff member at two different hospitals in Mendocino County, California. Dr. Hoek was asked by both hospitals to observe 10 surgeries performed by a surgeon who was applying for credentials at each respective hospital. Dr. Hoek was then to submit a written report to each hospital's credentials committee.

Prior to each of the two operations, Dr. Hoek reviewed Ms. Clarke's x-rays and discussed the operative plan with the surgeon to be observed. Otherwise, Dr. Hoek did not take any part in the care or treatment of Ms. Clarke. During the actual operations, Dr. Hoek was not asked to, and did not, participate in the surgeries. Dr. Hoek did not scrub in for the surgeries, instead observing them from a position outside the sterile field. Dr. Hoek never met Ms. Clarke before either surgery and was not paid for his proctoring duties.

In affirming the trial court's dismissal of Dr. Hoek as a matter of law, the *Clarke* court reasoned that, "absent a special relationship giving rise to a duty to act, a person is under no duty to take affirmative action to assist or protect another, no matter how great the danger in which the other is placed or how easily he could be rescued." *Id.* The *Clarke* court ultimately held that there was no special relationship between Dr. Hoek and Ms. Clarke which would create a duty for the proctor to act. The *Clarke* Court found that Dr. Hoek's only responsibility was to observe the treating surgeon perform surgery, not to supervise. *Id.* The *Clarke* court even went so far as to say "[t]he fact that appellant's doctor experts opined that [the medical proctor] had a duty to 'ensure that the patient receives proper surgical treatment within the standard of care' and that failure to intervene falls below the standard of care does not create a triable issue of fact." *Id.*

The Lucas County, Ohio, Court of Common Pleas came to a similar conclusion in its analysis of the medical liability of proctors in *Zablocki v. Wilkin*, 2003 WL 25580058 (Ohio Com. Pl. 2003). In *Zablocki*, the Plaintiff suffered a fractured right ankle after falling in her home. She was ultimately referred to a podiatrist, Dr. Wilkin, to perform surgery on her injured ankle. Dr. Wilkin had recently been credentialed at a local hospital and was required to have a proctor in attendance for his first five surgeries performed at this hospital. Dr. Walkovich was appointed by the local hospital to serve as Dr. Wilkin's proctor for Ms. Zablocki's surgery. Dr. Walkovich was not paid for his proctoring services, did not scrub in and was not present for the entire procedure. Although he admitted to discussing Ms. Zablocki's procedure with Dr. Wilkin before the surgery, Dr. Walkovich testified that his "sole function as a proctor was to observe another doctor for purposes of determining if that doctor has demonstrated the skills necessary to justify an extension of privileges." *Id.*

Ms. Zablocki later filed a medical malpractice action against Drs. Wilkin and Walkovich, among others. Ms. Zablocki alleged that Dr. Walkovich failed to properly supervise Dr. Wilkin in the surgical procedure. However, the Ohio Court of Common Pleas dismissed her action as a matter of law, finding that a "physician who, on behalf of a hospital and without compensation, acts as a proctor in observing a surgical operation for the sole and express purpose of assessing and reporting on the competence of a candidate for membership of a hospital medical staff" does not owe a duty to a patient to "intervene in that surgery in order to prevent malpractice by the proctored surgeon." *Id.*

From these two cases it is apparent that some of the most important factors to eliminate a proctor's liability for the negligence of an observed physician, include: 1) the proctor's lack of participation in the surgery; 2) the proctor's not scrubbing in; 3) the proctor's positioning outside of the sterile field; 4) the proctor's absence for portions of the procedure; 5) the proctor not meeting or examining the patient pre-surgically; 6) the proctor's appointment by an outside body to serve as proctor; and 7) the proctor's lack of compensation for observing.

In contrast are cases where a physician clearly has a duty to supervise and instruct less experienced physicians. Such cases frequently involve on-call or supervising physicians overseeing resident physicians. In these cases, the on-call/supervising physician is often found to owe patients a duty to properly supervise the less experienced practitioners who independently treat these patients. This relationship between supervising physicians and physician residents or mid-wives often creates liability for the on-call/supervising physician for failing to interject in a

patient's treatment. *See, e.g., Mozingo by Thomas v. Memorial Hospital*, 415 S.E.2d 341 (N.C. 1992); *Miller v. Phillips*, 949 P.2d 1247 (Ak 1998); *Arpin v. U.S.*, 521 F.3d 769 (7th Cir 2008). A similar duty exists when supervising physicians fail to confirm that a surgical procedure was performed properly by medical residents at a teaching hospital.

In *McCullough v. Hutzel Hospital*, 276 N.W.2d 569 (Mich. 1979), the Michigan Court of Appeals found that supervising surgeons were liable for the negligent performance of surgical procedure performed by residents. In this case, Ms. McCullough underwent a tubal ligation, supposedly rendering her incapable of conception. However, several months later she became pregnant and, due to the health concerns that necessitated the tubal ligation, was forced to undergo an abortion. She sued for damages. In finding that the supervising surgeon's liability was "not predicated on the negligence of the resident but upon their own negligence in failing to provide adequate supervision," the Court ruled that even though the surgical procedure was actually performed by a resident, the supervising preceptor surgeons were under a duty to assure that the procedure was performed properly. *Id*. Any failure to make sure the procedure was complete and performed properly could render them liable for the resulting damages.

In *Lownsbury v. VanBuren*, 94 Ohio St.3d 231 (Ohio 2002), the Ohio Supreme Court found that enough evidence existed to preclude summary judgment that an attending physician could be liable for the negligent treatment provided by residents to a baby born with severe brain damage and for the prenatal care provided to the mother. The court found the attending physician voluntarily assumed a duty of supervisory care pursuant to his contractual and employment agreement with the teaching hospital. The defendant-attending had no direct or indirect contact with the patient, was not consulted by the treating residents, or otherwise actively involved in the patient's care. *Id*. However, the court specifically found that a consensual physician-patient relationship could be established between a physician who contracts, agrees, undertakes, or otherwise assumes the obligation to provide resident supervision at a teaching hospital.

Similarly, in *Mozingo v. Pitt Cty. Mem. Hosp., Inc*., 331 N.C. 182 (N.C. 1992), the Supreme Court of North Carolina held that a physician who undertook to provide on-call supervision of obstetrics residents at a teaching hospital owed an infant plaintiff and his parents a duty of reasonable care in supervising the residents who delivered plaintiff at his birth. In this case, Sandra Dee Mozingo was admitted to the hospital on the afternoon of December 5, 1984, for the delivery of her second child, plaintiff Alton Ray Mozingo, Jr. At 5:00 p.m. Defendant Dr. Richard John Kazior was the on-call physician for the obstetrics residents at the hospital. Dr. Kazior remained at his home available to take telephone calls from the residents until shortly before 9:45 p.m., when he received a call from one of the residents informing him of a problem with the delivery of Alton. Dr. Kazior immediately left his home, but when he arrived at the hospital the delivery of Alton had already been completed.

The plaintiffs in *Mozingo* (baby Alton and his father) claimed that Dr. Kazior had negligently supervised the residents who cared for Alton and his mother during his birth. However, there was no claim that Dr. Kazior was negligent in responding to the telephone call from the hospital, or in anything he did or failed to do after receiving the call. Instead, the plaintiffs' claim for negligent supervision was based on what Dr. Kazior failed to do prior to receiving the request for assistance. Specifically, plaintiffs submitted the affidavit of a medical expert who stated that Dr. Kazior had a responsibility as the supervising physician to call the hospital at the beginning of

his coverage shift to find out what obstetrical patients had been admitted, their condition, and to formulate a plan of management, and also to call periodically thereafter to check on their status. In this case, it was undisputed that prior to receiving the phone call, Dr. Kazior was never in direct contact with the patient, consulted by the treating residents, or in any way involved in the patient's care.

The court noted that the defendant's duty of reasonable care in supervising the residents was not diminished by the fact that his relationship with the plaintiffs did not fit traditional notions of the doctor-patient relationship and that "large teaching hospitals, such as the Hospital in [this] case, care for patients with teams of professionals, some of whom never actually come in contact with the treated patient but whose expertise is nevertheless vital to the treatment and recovery of patients." *Id*. The North Carolina Supreme Court ultimately held that "a physician who undertakes to provide on-call supervision of residents actually treating a patient may be held accountable to that patient, if the physician negligently supervises those residents and such negligent supervision proximately causes the patient's injuries." *Id.*

Although these cases do not directly outline the duties of a preceptor or supervising/on-call physician, one can presume that the existence of the following elements would be more likely to result in a finding that an observing surgeon was more than a proctor and owed a duty to intervene if improper care was occurring: 1) a contractual duty to supervise or respond to a call; 2) a clear agreement by the observing physician to supervise and guide the treatment of another physician; 3) voluntary substantial interjection in the decision making surrounding a patient's care; 4) signing of medical records; and 5) involvement in the patient's post-surgical care.

Further distinguishable from a proctor setting are the cases where a physician relies upon the judgment or interpretation of another physician in making treatment decisions for a patient. This reliance usually serves as the basis for subjecting the consulted physician, who may have never actually met the patient, to liability. This commonly is characterized as an "implied physician-patient relationship" and most often arises in situations where specialists, such as a radiologist, interpret lab results or other types of testing. *See, e.g., Raptis-Smith v. St. Joseph's Med. Cntr*., 302 A.D.2d 246 (N.Y. App. Div. 2003); *Walters v. Rinker*, 520 N.E.2d 468 (Ind. Ct. App. 1988).

In *Raptis-Smith v. St. Joseph's Med. Cntr*., 302 A.D.2d 246 (N.Y. App. Div. 2003), summary judgment was denied where a radiologist argued he did not have a physician-patient relationship with the plaintiff because he never met the patient and only reviewed x-rays at the request of the treating physician. In this case, the court held that an implied physician-patient relationship can arise when a physician gives advice to a patient, even if the advice is communicated through another health care professional. The court further noted that it was not necessary that the radiologist see, examine, take a history, or treat the patient to render medical services. *Id*. The fact that the radiologist's interpretation of the x-ray was relayed to the patient through another physician was enough evidence of an implied physician-patient relationship to defeat summary judgment.

Likewise, in *Walters v. Rinker*, 520 N.E.2d 468 (Ind. Ct. App. 1988), the court denied summary judgment and found an implied physician-patient relationship could exist between a patient and a pathologist that never examined, saw, or treated the patient. The pathologist examined

plaintiff-patient's tumor specimen at the request of a third party doctor. The pathologist diagnosed it as being benign when it was in actuality malignant. The pathologist also argued that since he reviewed the tumor at the request of a third party and not the patient, a consensual relationship could not have existed. The court disagreed with both contentions and denied summary judgment.

Further, enough evidence of an implied physician/patient relationship existed to defeat summary judgment in *Bovara v. St. Francis Hospital*, 298 Ill. App.3d 1025 (Ill. Ct. App. 1998). In *Bovara*, the physician treating the patient called defendant physicians at another hospital who had a contract with the treating physician's hospital to perform cardiac interventionist review. Per hospital procedure, the treating physician inquired whether the patient was a candidate for an angioplasty from the defendant physicians. The defendant physicians reviewed the patient's angiogram film and decided the patient was a candidate. Defendant physicians never reviewed the patient's medical records, spoke with, or examined the patient himself. A different physician performed the surgery in which the patient ultimately died.

The court held enough evidence existed to survive summary judgment that the consulted defendant physicians had an implied physician-patient relationship. A crucial point to the court in *Bovara* was that the consulted physicians were performing a service rendered for the benefit of the patient as opposed to informally helping out a colleague. The court specifically likened this process to when a physician relies upon the expertise of a radiologist or pathologist who interprets results for a physician that is incapable of properly interpreting those results himself. Thus, a distinguishing characteristic is that the defendant physicians were interpreting results that were in turn relied upon by the treating physician in determining the patient's care and treatment plan.

From these cases it is obvious that an implied physician-patient relationship may arise and possibly be an avenue to subject a proctor to liability despite never examining a patient or reviewing his medical records. Elements to look for when determining if an implied duty may arise are: (1) interpretation of diagnostic testing; (2) formal procedures requiring a specialist's review before treatment decisions are made; (3) reliance upon a consulted physician's opinion by another physician who lacks expertise in the area; and (4) formal consultation that is for the benefit of the patient. In order to shield proctors from liability a patient consent form, such as the one at the conclusion of these materials, is advisable.

IV. The Outcome of the Prostate Proctor

In the previously discussed prostate proctor case, Lee's physician client contended that, as a proctor, he did not have a physician/patient relationship in his role. He presented evidence that the client never met the patient prior to surgery, was not given hospital privileges to participate in the surgery or a temporary medical license in South Carolina. He also contended that the error in leaving prostate tissue behind was one that could not be detected visually by anyone observing the surgery outside the controls of the robot. Despite this evidence, the court found a factual dispute existed enough to allow the case to be heard by a jury. However, the jury ultimately found a physician-patient did not exist and absolved our client from liability.

SAMPLE CONSENT TO PROCTORING SURGEON SERVICES

I understand that the proctoring surgeon ("Proctor") has been retained by the hospital, attending physician and/or surgeon, or party otherwise responsible for providing medical treatment to me solely in order to offer consultation services on the surgical device(s) that will be used to perform the following operation and/or procedure which I agreed to undergo:

_____
_____
_____

I understand that the Proctor shall not be responsible for any complications or malfunctions that may result from the operation itself nor from use of the surgical equipment. My attending physician and/or surgeon and I have discussed the risks and complications involved with use of the following surgical device(s):

_____
_____

ACKNOWLEDGEMENT:

I understand that the Proctor shall not assume any supervisory role over the attending physician and/or surgeon responsible for the operation and/or procedure by performing any of the acts listed below. I understand the following acts to be part of consultation services only and that they shall not be construed to create a duty owed to me by the Proctor. Nor shall these acts be construed to establish a fiduciary physician-patient relationship between myself and the Proctor or a violation thereof:

- assisting, coaching, and training the attending physician and/or surgeon regarding how to perform the particular procedure(s) through use of the surgical device(s) for the benefit of all parties including the medical device company, the hospital, the attending physician and/or surgeon, and the patient;
- presence at, observation of, and assistance given to the attending physician and/or surgeon during the course of the operation and/or procedure;
- following or failing to follow established hospital protocol;
- explaining, reviewing, or in any way contacting the patient regarding the surgical device(s) to be used by the attending physician and/or surgeon in performing the operation and/or procedure;

CONSENT:

In signing below, I acknowledge that I UNDERSTAND and AGREE to the information detailed above:

_____ _____
(Patient's Signature) (Date)

_____ _____
(Proctor's Signature) (Date)

_____ _____
(Attending Physician and/or Surgeon's Signature) (Date)